Best Practices in Treatment Planning for Adults Who Have Sexually Abused

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Safer Society FOUNDATION

Outline

- Katie: The nexus of risk domains, protective factors, and evidence-informed decision-making
- David: Extracting information, goal setting, and process issues
- Seth: Pulling the pieces together

Evidence-Based

or

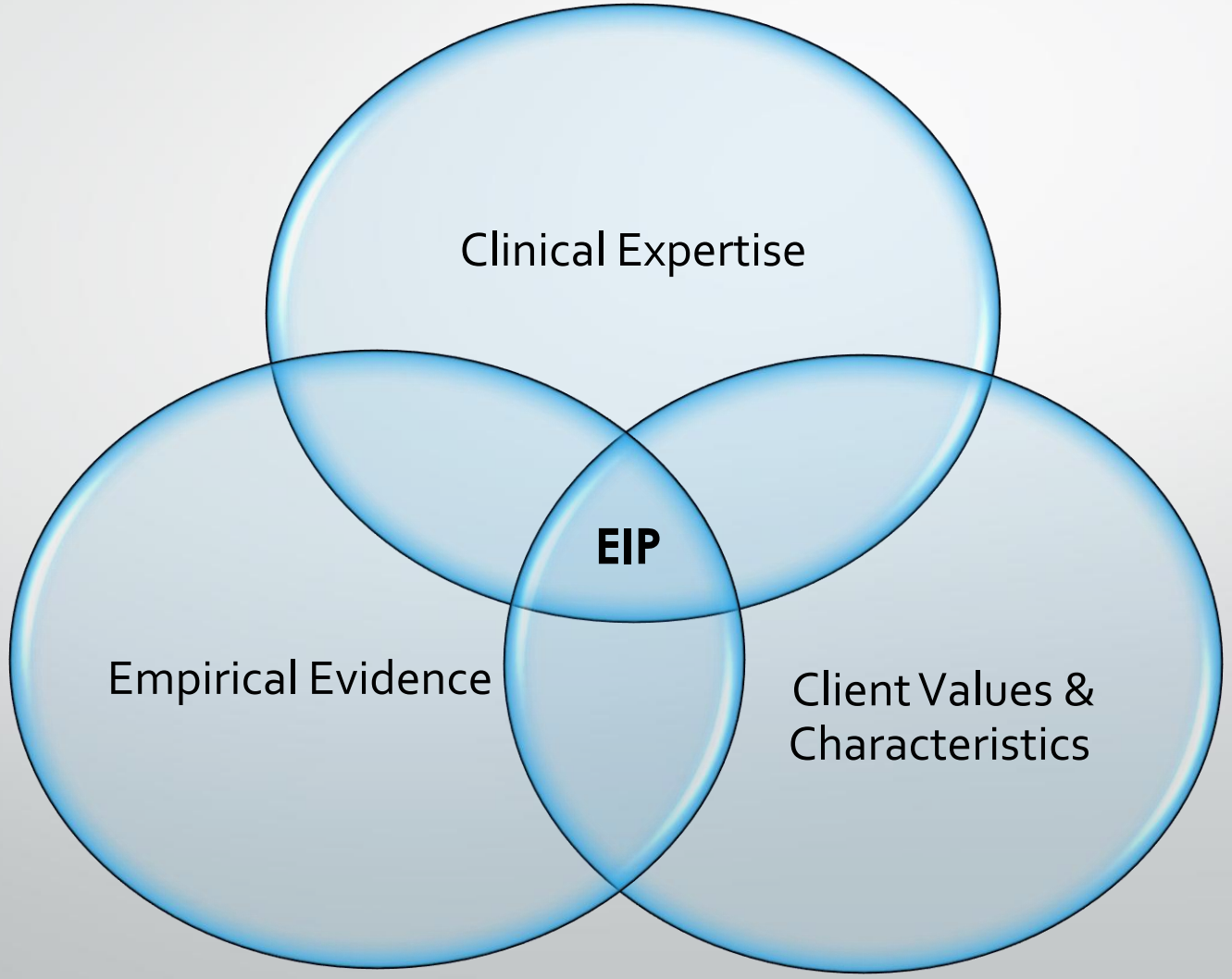
Evidence-Informed?

- Evidence-Based = rigorously evaluated, tested, replicated
- Evidence-Informed = aligned with and supported through research

What is Evidence-Informed Decision Making?

- Policy
  - Legislation, court decisions based on objective data rather than myths, assumptions, and public pressure
  - Incorporate individual differences and person-level characteristics
- **Practice**
  - Supervision and treatment based on risk, needs, responsivity, protective factors
  - Focus on providing a path to success through collaboration
  - Equity of services regardless of race, power, privilege

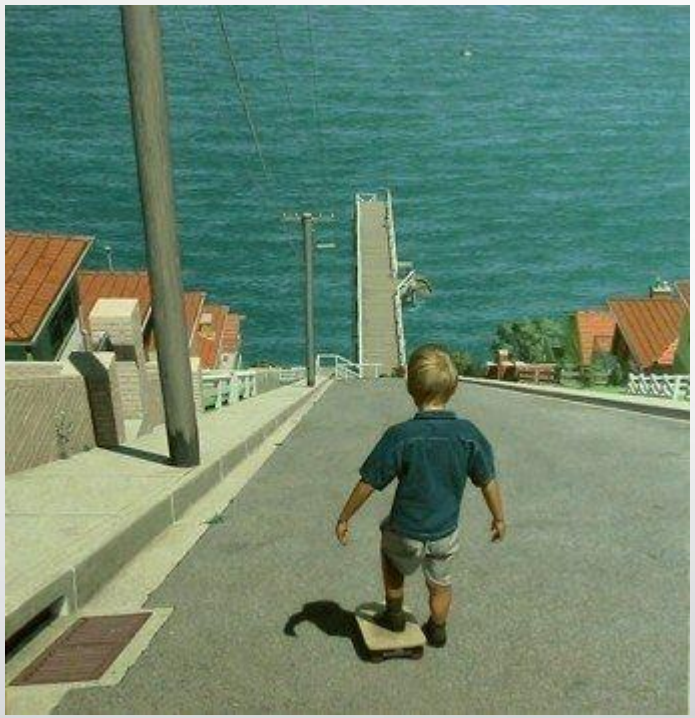
Evidence-Informed Practice



Risk Assessment & Treatment Planning

"Criminal behavior can be predicted + levels of services should be matched to the risk level of an offender."

~Andrews & Bonta



"A risk is a hazard that is incompletely understood and whose occurrence can be forecast only with uncertainty."

~Stephen Hart

Risk Domains

- Psychological
  - Cognitive, Emotional and Behavioral
- Interpersonal
  - Intimate, familial, and peer relationships
- Lifestyle
  - Employment, housing, education, leisure, and substance use

Good Risk Assessment Tools

- Developed and validated through research.
- Assess empirically informed static and dynamic risk factors.
- Applicable to a wide range of situations and individuals.
- Get similar results when used with different populations.
- Can assess if there has been a change.
- Moderate levels of predictive ability.
- Used by trained individuals who are consistent and conscientious about applying the tools in the appropriate manner (e.g., following the coding rules, etc.).

Risk Assessment Tools*

- **General Risk Assessment**
  - LSI-R; LS/CMI
  - COMPAS
  - ORAS
  - IORNS
- **IPV/DV**
  - ODARA
  - DVRAG
  - SARA
  - SAM

*not an exhaustive list

- **Violence Risk Assessment**
  - VRAG
  - HCR - 20
- **Sexual Risk Assessment**
  - Static-99R/STABLE & ACUTE-2007
  - RSVP
  - VRS-SO
  - SOTIPS
- Psychopathy Checklist Revised (2nd Ed)

Time Horizon

- How long do risk estimates last?
  - Long-term vs. short-term risk assessment
- How often should they be revisited or repeated?
  - Treatment effects
  - Changes in risk status due to other circumstances
  - New information becomes available that substantially changes risk estimates
  - Desistance

Putting it all together…

"The purpose of risk assessment is to speculate in an educated way about the violence that an individual might commit, and to identify what is required to stop such violence from occurring"

~Hart, et al., 2003

i..n...t.e...g...r.a..t...i.o.....n

Case Formulation

- Describe the individual in context
- Identify relevant risk factors
- Identify strengths and protective factors
- Estimate & describe risk for reoffending
- Specify treatment needs
- Identify any barriers to treatment
- Assess amenability to treatment
- Provide recommendations (risk management plan)

Risk Formulation

- Worst case scenario…
  - Who might the likely victims of violence be?
  - What is the nature of what they are likely to do?
  - How imminent would you expect this person to act violently?
  - What is the likelihood that they will/would become violence?
    - If the likelihood is low, say why.
- Best case scenario
  - What would desistance look like for this person?

Creating an Integrated Risk/Needs Treatment or Case Plan

- Write clear treatment/case plans based on ***individualized*** risk/need profiles
  - Identify intervention targets – think SMART goals
  - If denying clients certain privileges, be clear about what will need to happen for them to earn such privileges back
  - Collaborative process
- Treatment/case plans should be updated regularly (a minimum of every 90 days)
  - Regular updates demonstrate progress
  - Allow for achievement of short-term goals
  - Allow for readjustment when new challenges arise
  - Include rewards/positive reinforcers

Treatment & Intervention Dosage

- General guidelines:
  - Very low/below average risk: limited to no interventions, no more than 100 hours
  - Average risk: 100 to 200 hours
  - Above average/well above average risk: 200 to 300/200 to 300+ hours
- Progress is individual specific and may be impacted by varying factors, such as:
  - Client motivation
  - General lifestyle stability (or lack there of)
  - Responsivity factors
  - Resource availability/system issues
  - Progress across domains (supervision v. treatment)

Protective Factors:

Structured Assessment of Protective Factors for Violence Risk (SAPROF)

Internal Factors

- Intelligence
- Secure attachment in childhood
- Empathy
- Coping
- Self-control

Motivational Factors

- Work
- Leisure activities
- Motivation for treatment
- Attitude towards authority
- Life goals
- Medication

External Factors

- Social network
- Intimate Relationship
- Professional care
- Living circumstances
- External control

Protective Factors: Sexual

(as proposed by de Vries Robbe, Mann, Maruna, & Thornton, 2015)

- Underlying propensities - not just ***absence*** of a risk factor:
  - Healthy sexual interests
  - Capacity for emotional intimacy
  - Constructive social & professional supports
  - Goal directed living
  - Good problem-solving capacities
  - Engaged in employment or constructive leisure activities
  - Sobriety
  - Hopeful, optimistic and motivated attitude about desistance

Protective Factors: SAPROF-SO Version 1

(Willis, Thornton, Kelly & de Vries Robbe, 2021)

- Factors which help mitigate risk
- Provides *Approach Goals*

Coding sheet SAPROF-SO – *Version 1*

For use in conjunction with sexual recidivism risk assessment instruments

Name:	**Date:**
DOB: **Ethnicity:**	**Sex:** ❑ Male ❑ Female ❑ Gender diverse
Current context: **Future context/s (optional):**	
Name assessor(s):	

		Score (0,1,2,3,4)	
Resilience		**Current**	**Future**[1]
1.	Adaptive schemas		
2.	Empathy		
3.	Coping		
4.	Self-control		
5.	Attitudes towards rules and regulations		
	Resilience Total		
	Resilience Average *(Total/5)*		
Adaptive Sexuality			
6.	Sexual self-regulation #1= #2= #3= #4=		
7.	Prosocial sexual interests		
8.	Prosocial sexual identity		
9.	Intimate relationship		
	Adaptive Sexuality Total		
	Adaptive Sexuality Average *(Total/4)*		
Prosocial Connection & Reward			
10.	Goal-directed living		
11.	Work		
12.	Leisure activities		
13.	Social network		
14.	Emotional connection to adults		
	Prosocial Connection & Reward Total		
	Prosocial Connection & Reward Average *(Total/5)*		
	TOTAL SAPROF-SO SCORE		
	AVERAGE SAPROF-SO SCORE *(Total/14)*		

Professional Risk Management (optional items)		**Current**	**Future**[1]	**Long-term**[2]
P1.	Sexual offence-specific treatment ❑ N/R			
P2.	Therapeutic alliance ❑ N/A			
P3.	Motivation for managing risk ❑ N/A			
P4.	Medication ❑ N/A			
P5.	Supervised living			
P6.	External control			
	Professional Risk Management Total			
	Professional Risk Management Average *(Total/applicable items)*			

[1] Optional ratings for proposed future context/s

[2] Complete when sentence conditions, supervision/case management, and/or group home level care will continue for at least 3 years

Desistance and Case Planning

- **Recommendation**: Policies designed to manage risk of sexual recidivism need to include mechanisms to adjust initial risk classifications and determine time periods where individuals with a history of sexual crime should be released from the conditions and restrictions associated with the "sexual offender" label.
- Consider:
  - Treatment dosage/type of programming
  - Intensity of Supervision
  - Special Rules
  - Electronic Monitoring
  - Other Restrictions?
  - Consensus among multidisciplinary team?

Questions?

Four Frameworks

- The Therapeutic Alliance
- Motivational Interviewing
- Good Lives Model
- Feedback-Informed Treatment

The client just turned 21. He has high-functioning Autism, which is most apparent in his social interactions and rigid thinking. He can also be quite paranoid and suspicious of others' intentions. He has a long history of being violent towards his family and he was more recently stalking a young woman in school. He spent some time in a treatment program in another country. He wants to meet a woman and have a family. However, his planning is very rigid indeed. He intends to meet a woman, and then move to London, and then to New York City. He intends to accomplish this in five years. Where do you start in using the Good Lives Model?

Risks

- History of violence
- Recency of violence (?)
- Stalking persisting despite concerns expressed by others
- No history of positive relationships
- Problem-solving skills?
- Self-regulation skills?
- Attitudes and beliefs?

Preliminary Strengths/Protective Factors

- Desires the stability of relationships and family life
- Wants to know how he fits into the world around him/seeks knowledge
- Apparently stable in other areas of his life
- No expressed concerns about medications
- Involved with services

The Good Lives Model (GLM)

"…[our clients] want better lives, not simply the promise of less harmful ones"

(Ward, Mann, & Gannon, 2007)

Important Skill

- Going Upstream:
  - What's the larger goal behind the immediate goal or clinical presentation?
  - "I'm not gonna" and "you can't make me" reflect deeper goals around autonomy and relationships.
  - "I'm not the same person as I was then" reflects avenues for inquiry regarding identify.
  - Please note that one statement or action can reflect multiple goals!

Good Lives Model Goods/Goals

- Relationships and friendships
- Independence and autonomy
- Knowledge
- Spirituality: Meaning and purpose
- Inner peace
- Happiness and pleasure
- Living and surviving

Goods/Goals Implicated in Violence and Stalking

- Relationships and friendships
- Living and surviving
- Independence/autonomy (inc. personal choice)
- Knowledge
- Happiness and pleasure

Obstacles to Good Life Plan

- Internal capacity: lacking relationship skills, problem-solving skills, coping skills, independent living skills

➔

- Use of inappropriate means to attain goods/goals

➔

- Narrow scope of good life

➔

- Conflict between goals and goods

1979: Edward S. Bordin

- Therapeutic alliance:
  - Agreement on goals
  - Agreement on relationship
  - Agreement on tasks
  - (Norcross, 2002, would add client preferences)

- Over 1,100 studies have emphasized the importance of the alliance in psychotherapy since (Prescott et al., 2022)

Upstream

- Trust
- Uncertainty
- Shame
- Where does safety lie?
- What does he do with pain?
- How has he been hurt in the past and what how did he make sense of it all?
- What else would he do if he could just cut loose and be free?
- What is he longing for?
- Who is he longing for?

Ambivalence

Ambivalence

- I want to talk with you and I don't want any more trouble
- I want to work with you, and I don't want to look like a fool
- I want to tell the truth and I want my family to still love me
- I want to change, and I want to be respected
- I want to be in treatment, and I don't want to be in a one-down position
- I want to look at myself, and I don't want to feel less manly
- etc. etc. etc. etc. etc.

Are We Ready?

Motivation = importance + Confidence

Good Life Goals

(Yates & Prescott, 2011)

Good Lives Model Goals

Life: Living and Surviving

Knowledge: Learning and Knowing

Being Good at Work & Play

Personal Choice and Independence

Inner Peace/Peace of Mind

Relationships and Friendships

Community: Being Part of a Group

Spirituality: Having Meaning in Life

Happiness

Creativity

GLM vs. Andrews & Bonta Big 8
(Possible comparison)

GLM

- Happiness/Pleasure
- Creativity
- Knowledge
- Being good at work and play
- Personal choice/independence
- Relationships and friendships
- Meaning and purpose in life
- Peace of mind
- Community
- Living and surviving

Big 8

- Substance abuse and other pleasure seeking
- Poor performance in school or work
- Impulsivity/self-regulation deficits
- Antisocial peer group/social isolation/family problems
- Antisocial history
- Aggression/irritability
- Attitudes and beliefs supportive of sexual violence
- Alcohol/drugs, reckless, dangerous behavior

Good Life Goals
(Prescott, 2018; Also Print, 2013)

- Having fun
- Being an achiever
- Being my own person
- Being connected to other people
- Having a purpose in life
- Meeting my emotional needs
- Meeting my sexual needs
- Being physically healthy

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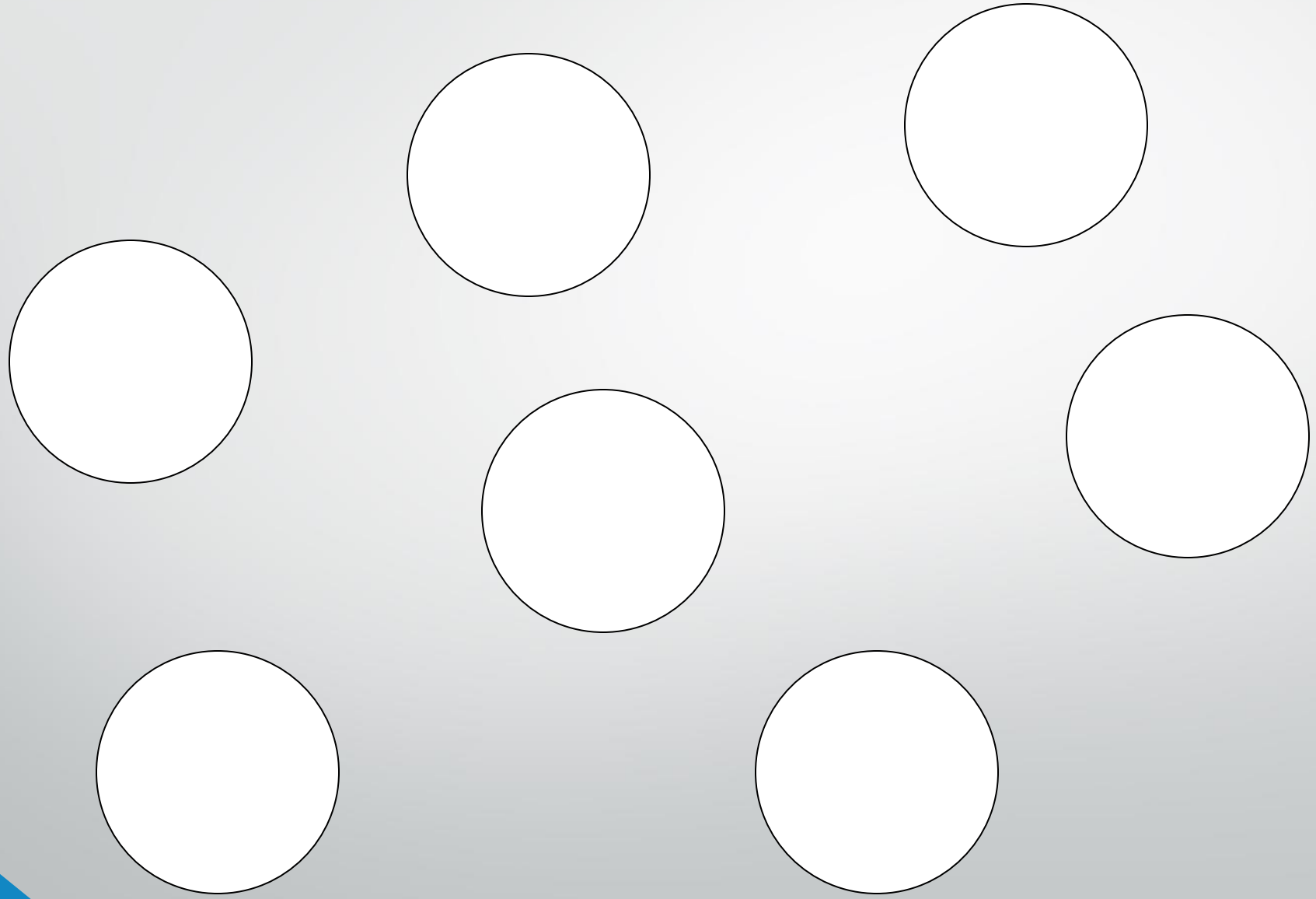
GLM vs. Andrews & Bonta Big 8

(possible comparison)

Options Menu



Options Menu

How have you been?

School

Relationships

Family

Home-work

Options Menu

How are you?

Recent Incident

Peers

Plans

A Good Options Menu

- Focuses the direction
- Respects client autonomy

Ideally

Telling “The Hard Truth”

- Elicit => Provide => Elicit
  - Ask permission to give feedback, give the feedback, then elicit the client’s thoughts about your feedback

Culture of Feedback

- Superior therapists elicit more negative feedback
- Atmosphere in which clients are free to rate their experiences
  - Without retribution
  - With a hope of having an impact
- Beyond displaying openness, this involves introducing available outcome measures thoughtfully and thoroughly
- Not just more forms to fill out!

Central Point

- "Love yourself as a person and doubt yourself as a therapist."
  - Helene Nissen-Lie

Openness and Surprise

ROUTINE OUTCOME MONITORING

- Tracking global outcomes
- Tracking the working alliance
- Session-by-session feedback
- Examples include Youth Outcome Questionnaire, Outcome Rating Scale, Session Rating Scale, etc.

OUTCOME RATING SCALE

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing*

Individually

(Personal well-being)

|----------|

Interpersonally

(Family, close relationships)

|----------|

Socially

(Work, school, friendships)

|----------|

Overall

(General sense of well-being)

|----------|

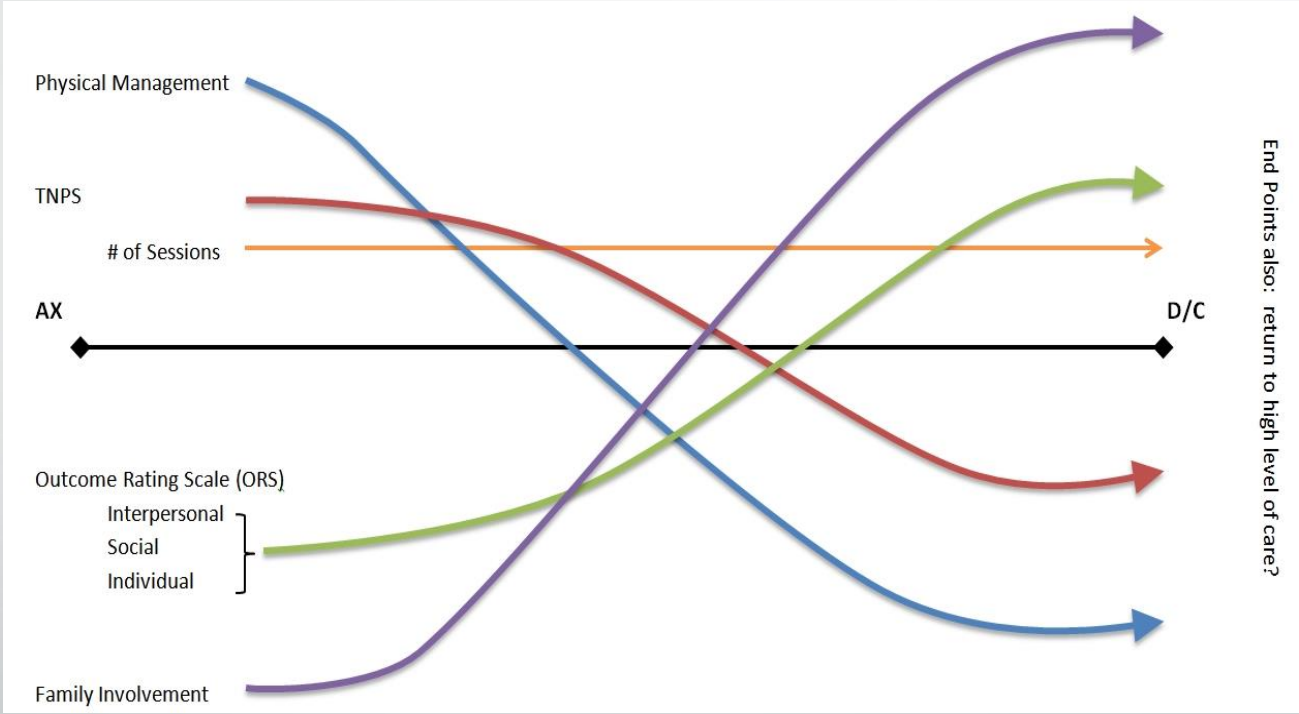
Session Rating Scale

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience:

I did not feel heard, understood, and respected	Relationship I----------I	I felt heard, understood, and respected
We did not work on or talk about what I wanted to work on or talk about	Goals and Topics I----------I	We worked on and talked about what I wanted to work on and talk about
The therapist's approach is not a good fit for me	Approach or Method I----------I	The therapist's approach is a good fit for me
There was something missing in the session today	Overall I----------I	Overall, today's session was right for me

(Miller, Duncan, & Johnson, 2002)

WELCOME TO MY WORLD



More Take-Home Skills

- Establish a culture of feedback
- Get actionable feedback:
  - Clients
  - Colleagues

When Supervising

- Begin with a case and consider:
- What are this client's goals?
- Who are you in this client's life, from his/her perspective?
  - (clarifying relationship)
- What things do and don't work for him/her in treatment
  - (clarifying tasks and approach of therapist)
- What cultural considerations exist?
  - Is the therapist taking these into account in constructing services?

Example

- The seemingly impossible case: Unmotivated, uninterested, has had enough of therapists
- Explore client goals
  - His desire for freedom and living in the community indicates a strong priority on personal choice and independence.
  - Set therapist goal of exploring other goals with interest and no agenda as part of a regular conversation; not overtly clinical
- Explore client relationship
  - Who is this therapist in the client's life? Just an innately annoying person? Define what the therapist can and can't do

Example

- Therapist approach
  - Open discussions about what is working for the client, what kind of approaches may be necessary, and why.
  - It may be as simple as “what’s in it for you”.
- Cultural considerations
  - What strongly held values assist or impede this case?
  - Client comes from a family in which receiving assistance of any kind is considered a sign of weakness.

Additional Treatment Process Ideas

and Process Challenges

Thinking On These Goals

- What will progress in this look like to me and others?
- What can I do to make positive changes in this?
- What problems might happen as I try to improve?
- How would I know when things aren't working?
- How would others know when things aren't working?
- What can I and others do when things start to go wrong?
- How can I and others acknowledge progress when it happens?

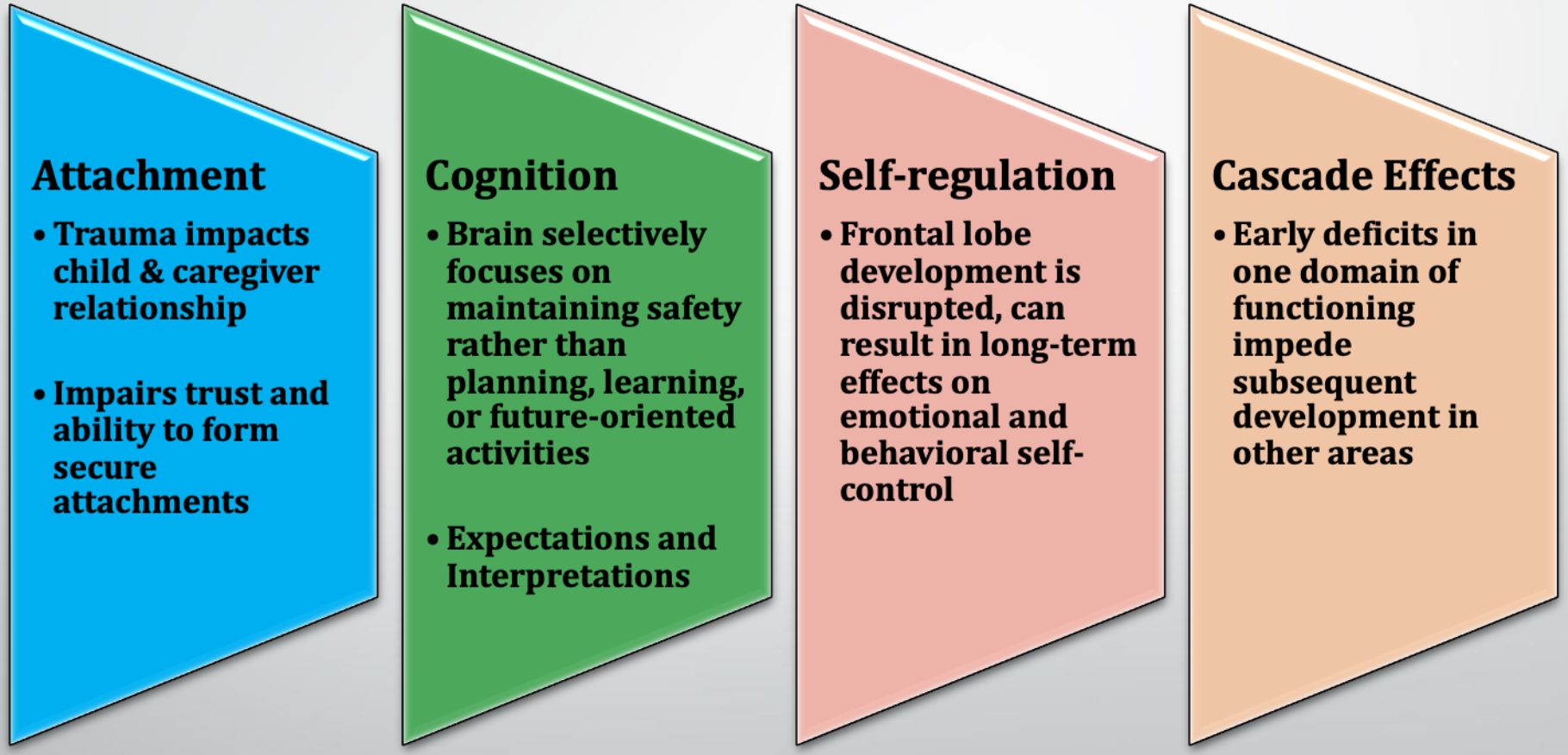
Thinking Further On These Goals

- How have traumatic and otherwise adverse experiences affected this person's ability to get this goal?
- How have the same experiences affected how he looks at the world?
- Where are all the places that this person may experience ambivalence about this goal?
- How can we elicit the client's internal motivation(s) regarding attaining this goal without harming others?

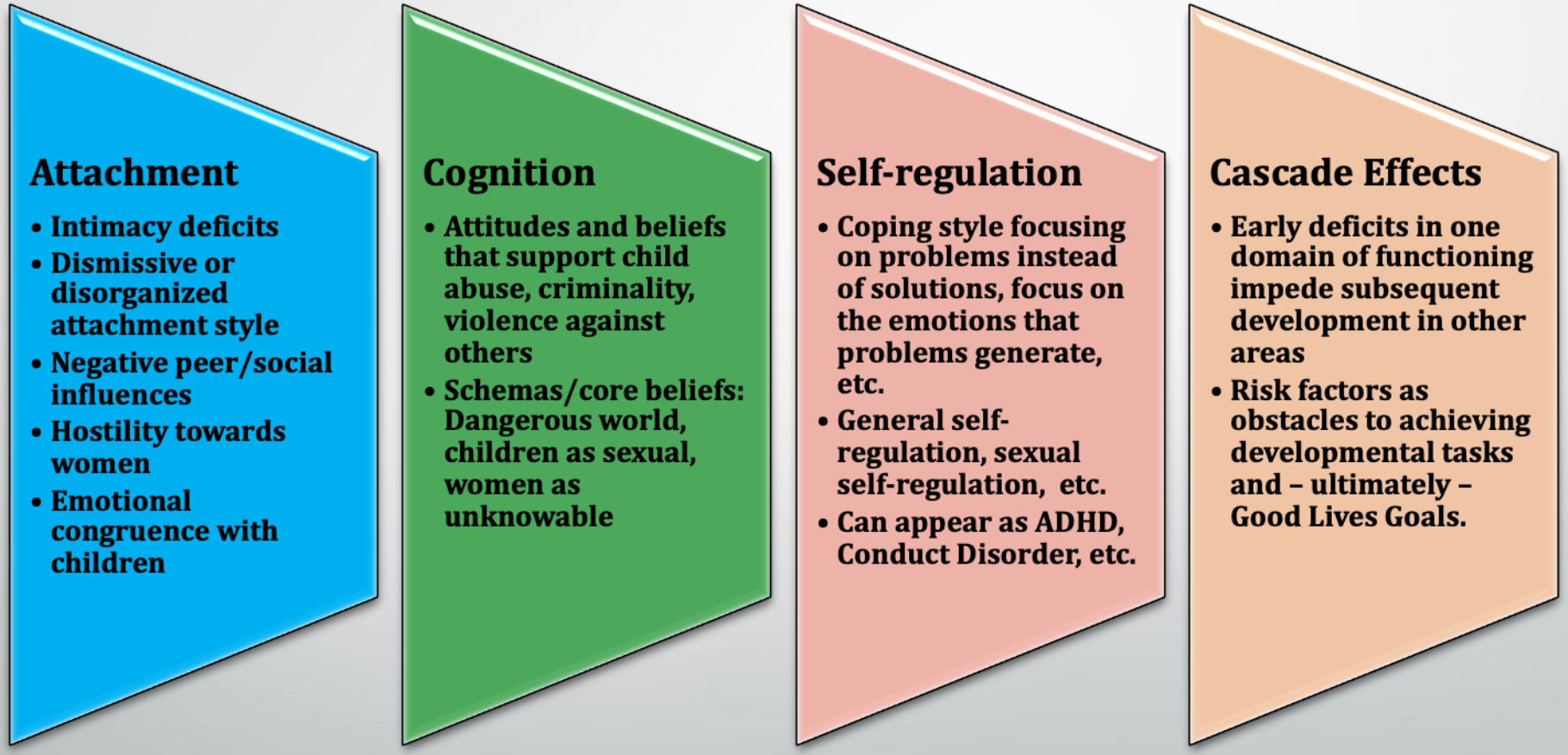
How Does Trauma and Adversity Affect Development?

And Risk Factors?
And Good Lives Goals?

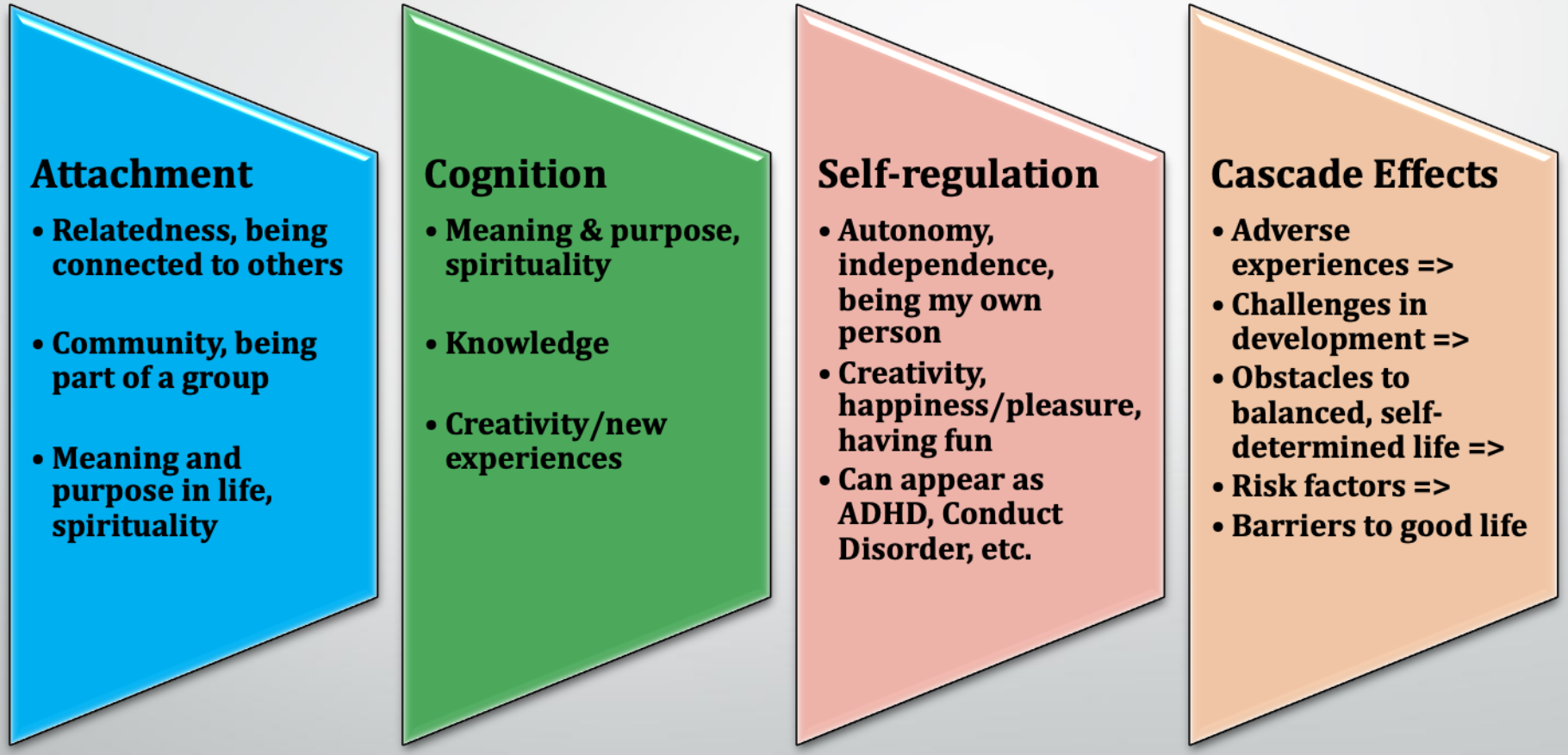
Developmental Effects of Childhood Adversity



Developmental Effects of Childhood Adversity and Risk



Developmental Effects of Childhood Adversity and Good Lives Goals



Finally…

Chunking Logic

- Taking big ideas and finding the components that make them up

"*When it doubt, chunk it out!*"

Empathy

(Adapted from Andrew, 2022)

- Listen with a goal of understanding
- Sit with what they say
- Consider what it's like to be them or what they must be thinking
- Seek the meaning beneath the words
- Respond with a gentle guess that starts by naming the meaning
- Watch how that response lands
- Tune in to their reactions and listen with a goal of understanding
- Repeat, going ever closer to accurate empathy

Staying Safe Sexually

(Adapted from Willis, Kelley, & Thornton, 2024)

- Managing stimuli/situations that may trigger offense-related impulses or provide opportunities for abuse
  - Awareness, attitudes, and behavioral choices that go beyond what the client may be compelled to do by external constraints
  - Can the client bring these to the attention of others appropriately and regularly
- Developing and implementing strategies to manage inadvertently encountered situations
- Interrupting offense-related sexual thoughts or impulses
  - For example, look-away skills, cognitive interruption of thoughts or impulses
- Healthy expression of sexual drive
  - Client not using sex to cope with negative affect

Active Participation

- Client brings topics for discussion, completed homework assignments, etc. into session without being prompted
- Behaviors indicate that client is working with professionals and not against them
- Client actively describes thoughts, feelings, situations, and behaviors that present challenges

Example

(gratitude to Brittany Decker & Dave McAllister, Laraway Programs of Vermont)

Historical and Current Presentation (not “presenting problem”)

Goals (with each followed by objectives/action steps and who is responsible)

- Physical Health & Wellness
- Mental Health & Wellness
- Interpersonal/Relationship Development
- Emotional Regulation/Expression
- Spiritual Development
- Family Relationships

Transition plans

Putting it all together

Connecting the puzzle pieces

Treatment Planning

- From the perspective of the public
- From the perspective of the field (best practice)
- From the perspective of the organization, agency, contractor
- From the perspective of the therapist
- From the perspective of the client

*Conflicts among these lead to friction

Points of Friction

- Competence
- Therapeutic Approach
- Systemic Tension

An example: Competence

Competence

- Therapist: “I need more training before I conduct a risk assessment”
- Supervisor: “Just read the coding manual, it tells you everything you need to know”

The Ambivalence of Competence

- Competence can be dispensed with
  - Expedience – we need to do this now, and we can get trained later
    - On the one hand, we need proper training, on the other hand, we don't have time
  - Financial – it costs too much to do it the way we want, so this will do
    - On the one hand, we'd like to invest in the right solution, on the other hand, it's too expensive
  - Operational – we are short-staffed, so we need you to step up and fill in
    - On the one hand, we recognize you're not trained, on the other hand, you're all we've got

Impact on Treatment Planning

- When competence is dispensed with – due to expedience, finances, or lack of resources
  - Outcome is less than ideal
- The treatment plan is meant to have a therapeutic (net positive) effect

Therapeutic Approach

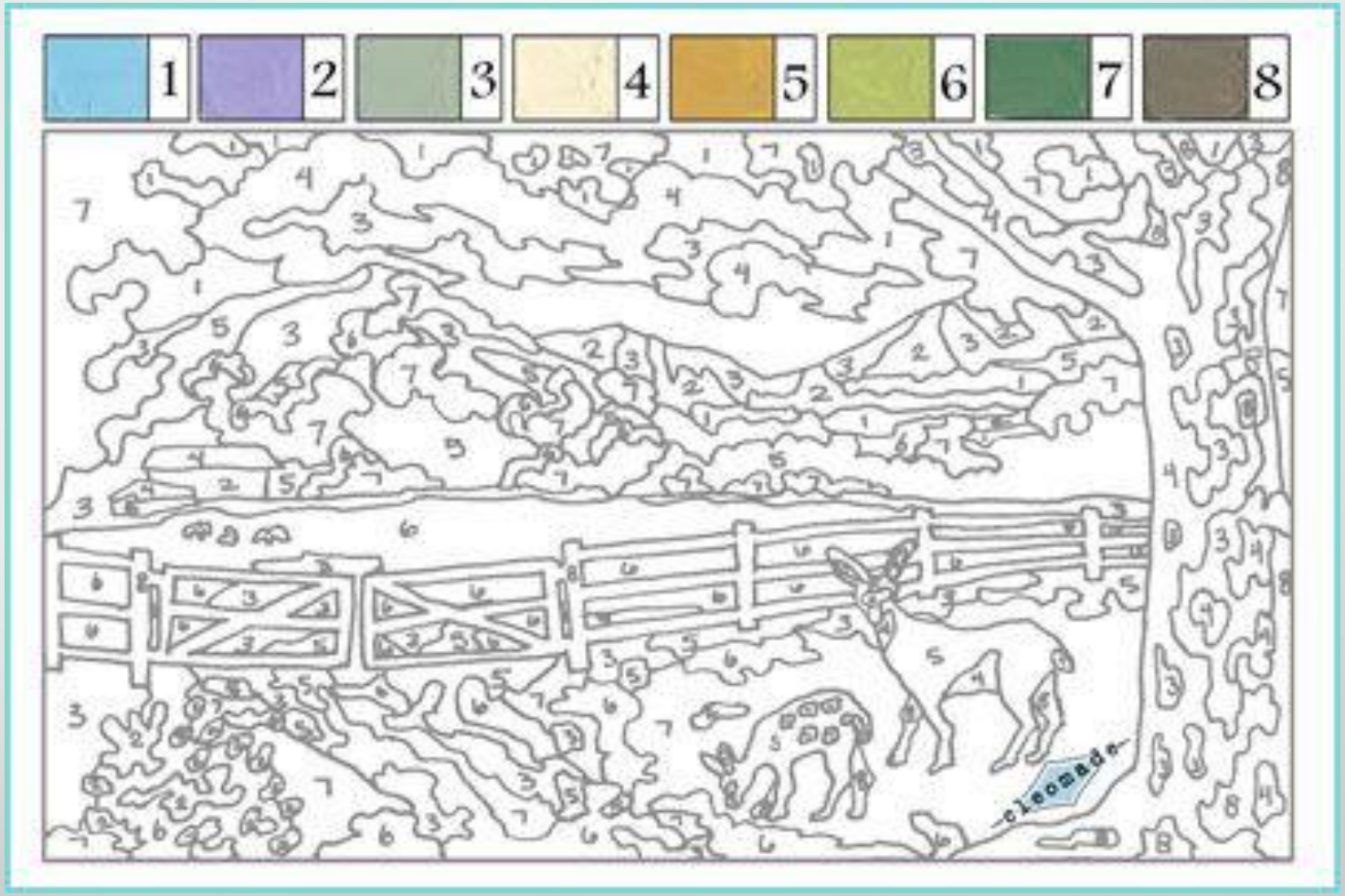
- Friction arises when
  - People don't believe that treatment is supposed to be therapeutic
  - Therapists aren't allowed to be…therapists

Therapeutic Approach

- William Marshall (2005)
  - Warm
  - Empathic
  - Rewarding
  - Directive

- Problem: Many people think they have these qualities, but don't

Paint by Numbers?



Background vs. foreground

Where are we going?

Ideally…

- Strong therapeutic alliance, partnership between therapist/client
- Goals are individualized, relevant, developed together
- Risk, need, responsivity *and* protective factors
- Ambivalence is expected and worked through
- Feedback is welcomed
- Best practice guidelines are followed

Systemic Tension

Policy – Best Practice = Systemic Tension

Ethical Challenges

- Ethical Challenge
  - Schofield, et. al. (2021)
    - Researchers have struggled to accurately define the term
    - Conceptual understanding of the term is lacking
  - Most agree ethical challenges involve **moral distress or discomfort** about a particular issue
  - These issues have to be 'overcome'

Ethical Dilemmas

- Ethical Dilemmas have two possible options, neither of which is 100% ethically acceptable
  - These issues have to be ‘resolved’

Ethical Challenge

We have a person on our list who is just plain hard. He is a 5 on the static even with a -3 for age. I'm trying to find the wording to explain our rationale for not placing him in our program. I have written about significantly high traits of psychopathy in prior assessments but the last time I did this, the SVP evaluator wrote (more or less) in her report that isn't true, and he should have been placed in programming because it has now been proven that individuals with high psychopathy can benefit from Cognitive-based programming. She quoted it from somewhere. I can't say she is wrong because maybe they can benefit from parts of a program, etc. etc… but we just can't deal with them

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Effective Treatment

- Gannon, et. al. (2019)
  - Treatment outcomes are enhanced when delivered by psychologists and qualified, trained mental health providers
- SAPROF-SO
  - Factor P1: Sexual Offense Specific Treatment
    - If treatment is recommended and appropriate, does it conform to RNR principles?
    - If yes, treatment can be a protective factor
    - If no, (that is treatment that is not available, or does not conform to RNR principles) is NOT a protective factor – therefore, treatment must not be one-size-fits all

What does our treatment plan look like?

- Client has a conviction for possession of CSEM, not allowed to live with his children on probation because they are minors (no criminal history)
- Client is unable to live with wife and children because they have Wi-Fi at the home
- Client who is 83 must be transported from the nursing home to treatment (no compassionate release)

Keep going forward!

What Really Matters

- If our primary goal is to create a world without sexual violence, we must
  - believe it is possible
  - speak the same language
  - agree on the facts
  - focus on rehabilitation and prevention

Where should we focus?

- Therapy that is WERD…that is
- Tied to GLM…performed within
- The RNR framework…highlighting
- Protective factors…that leads to
- Desistance.

- Thus, the overall goal is to help the person create a life that is rewarding and incompatible with offending

How do we do that?

- To promote evidence-informed decision making, we must learn the evidence
- To individualize treatment plans, we must eliminate one-size-fits-all practices
- To resolve ethical issues, we must be guided by research
- To be therapeutic, we must be what we were all trained to be - therapists